Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Positive Health Management

Respondent Name
El Paso ISD

MFDR Tracking Number
M4-07-3032-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
January 11, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Positive Health Management does not agree with these denials because these reductions are based upon the CPT codes only."

Amount in Dispute: $1,222.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…an additional allowance of payment was given in the amount of $704.88 (interest included) NovaPro Risk Solutions, issued a check 2/13/07, in the amount of $704.88 and the check number is 162837. No allowance is recommended for the other dates of service for code 90806."

Response Submitted by: NovaPro Risk Solutions, LP, 300 East Main, Suite 740, El Paso, TX 79901-1346

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2006 through August 25, 2006	90806, 97799 CP CA	$1,222.12	$369.89

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 131 – Claim specific negotiated discount.
   - 97H – Payment is included in the allowance for another service/procedure.
   - 213 – The charge exceeds the scheduled value and/or parameters that would appear reasonable.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?

2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code d) In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or, (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s). The carrier denied the disputed charges as 131 – "Claim specific negotiated discount." No documentation was provided in regards to support that a reimbursement rate was negotiated between the worker's compensation insurance carrier and the health care provider prior to the services being rendered; therefore 28 Texas Administrative Code §134.202(d)(3) does not apply. The services in dispute will be reviewed per applicable fee guidelines.
2. Per 28 Texas Administrative Code §134.202(c)(1) states in pertinent part, "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

   Per 28 Texas Administrative Code §134.202(5) states, "Return to Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier. (1) Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR. (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR. (5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes." Per the above rules the Maximum allowable reimbursement (MAR) will be calculated as follows;

Date of Service	Submitted Code	Units	Billed Amount	Carrier Paid	MAR Physician fee schedule allowable for El Paso, Texas multiplied by 125%
March 24, 2006	90806	1	$140.00	$74.34	95.16 x 125% = $118.95
March 31, 2006	90806	1	$140.00	74.34	95.16 x 125% = $118.95
April 21, 2006	90806	1	$140.00	74.34	95.16 x 125% = $118.95
May 5, 2006	90806	1	$140.00	74.34	95.16 x 125% = $118.95
May 12, 2006	90806	1	$140.00	74.34	95.16 x 125% = $118.95
June 2, 2006	97799CPCA	1	$875.00	817.38	125 x 7 = $875.00
August 18, 2006	90806	1	$140.00	0.00	95.16 x 125% = $118.95
August 25, 2006	90806	1	$140.00	0.00	95.16 x 125% = $118.95
		Total	$1,855.00	1,337.76	$1,707.65

The total MAR for the disputed services is $1,707.65. The carrier previously paid $1,337.76. The remaining balance is $369.89. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $369.89.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $369.89 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August 28, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.